COMMONWEALTH of VIRGINIA

RAPPAHANNOCK AREA CHILD DEVELOPMENT CENTER

Dear Parent/Guardian:

We look forward to meeting and working with you and your child. In order to provide the most comprehensive service, kindly complete the attached registration packet [to be completed by the LEGAL CUSTODIAN of the child to be evaluated]. Upon return of the completed registration packet, our office will mail you a letter of appointment.

☺ Please be sure to fill out completely. If the child is in the custody of anyone other than the biological parent(s), enclose a copy of the Court Order of Custody with the Judge's signature, or copy of Adoption Papers.

☺ We are Medicaid providers and provide services for some of the Medicaid HMOs.

☺ The State Health Department does charge for services based on a sliding scale. This is determined on the household total income and number of dependents. If you believe you may qualify for a reduced rate, enclose proof of total household income. If you do not provide proof of household income, or copy of Medicaid card, we are obligated to bill you for the current maximum fee. The parent/guardian with custody is/are responsible for the account in full. Payment is expected the day of service.

☺ The Authorization for Disclosure and Receipt of Protected Health Information forms [HIPPA Law] must be filled out completely with names, addresses, and telephone numbers where applicable. Please indicate **N/A** (not applicable) in sections that do not pertain to your child. The Authorization for Disclosure should typically include all providers listed within the registration packet. The [Beginning Date] is the date you are giving this office permission to send for the child's records.

Should you have any questions while completing this registration packet, do not hesitate to call our office at (540) 891-3151 and we will assist you with clarification.

Sincerely,

Child Development Center Staff

VDH Virginia Department of Health
Protecting You and Your Environment

BREEZEWOOD OFFICE PARK
10708 Ballantraye Dr., Su. 204
Fredericksburg, VA 22407
Phone: (540) 891-3151 Fax: (540) 891-3152

RAHD
Rappahannock Area Health District
CARING FOR A HEALTHY COMMUNITY

COMMONWEALTH of VIRGINIA

RAPPAHANNOCK AREA CHILD DEVELOPMENT CENTER

CONSENT FOR SERVICES

CHILD'S NAME: _____ Date of Birth: _____/_____/_____

CHILD'S SOCIAL SECURITY NUMBER: _____-_____-_____

I, the undersigned, am the legal guardian/parent of the above referenced child, and hereby give my consent to the Rappahannock Area Child Development Center for the following services:

1. Medical Evaluation by a Medical Provider to include physical examination, neurological screening, and a neurodevelopmental assessment.

2. Nursing Assessment by the Public Health Nurse to include family medical history, child's health history, developmental history, physical measurements, and health screening.

3. Psychological Evaluation by a Psychologist to include intellectual, developmental, behavioral, social, and emotional assessments. The evaluation includes interviews and questionnaires with parent(s)/guardian(s), and teacher(s).

4. Diagnostic Interview/Social Work Evaluation by a Social Worker, which will be done through parent(s)/guardian(s) interview, to include an overall review of family life and the child's environment.

5. Educational Evaluation by a State Educational Consultant, which may include: testing (at this Center or the child's school), parent(s)/guardian(s) interview, teacher conferences and/or school visits; or an assessment based on the findings of the evaluation by the other team members.

6. Photographing of my child. The photograph is kept in the child's file for identification purposes only.

SIGNATURE: _____ _____/_____/_____

Parent/Legal Guardian **Date**

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RAPPAHANNOCK AREA CHILD DEVELOPMENT CENTER

The Virginia State Health Department does not discriminate on the basis of disability in the admission or access to, or treatment or employment in, its programs or activities.

ALL BLANKS MUST BE FILLED IN COMPLETELY.

Child's Full Name: _____ Sex: __M__/__F__

Child's Social Security #: _____-_____-_____ **Date of Birth:** _____/_____/_____

Race: _____ Home Phone Number: (_____) _____-_____

Home Address: _____

City: _____ Zip: _____ County: _____

Mailing Address (If Different From Above): _____

City: _____ Zip: _____ County: _____

Name of Biological Mother: _____ DOB: _____/_____/_____

Mother's Social Security #: _____-_____-_____ Home Phone Number: (_____) _____-_____

Work Number: (_____) _____-_____ Cell Phone Number: (_____) _____-_____

Mailing Address (If Different From Child's): _____

City: _____ State: _____ Zip: _____ County: _____

Name of Biological Father: _____ DOB: _____/_____/_____

Mailing Address (If Different From Child's): _____

City: _____ State: _____ Zip: _____ County: _____

Father's Social Security #: _____-_____-_____ Home Phone Number: (_____)_____-_____

Work Number: (_____)_____-_____ Cell Phone Number: (_____) _____-_____

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Marital Status of Parents: □ Married □ Separated □ Divorced □ Single □Widowed □ Remarried

Child Resides With: □ Parents □ Mother □ Father □ Foster Care □ Legal Guardian
If child resides with other than the biological parent(s) on page 1, please complete the following:

Name: _____ Home Phone Number: (_____)_____-_____
Guardian/Foster Parent
Social Security #: _____-_____-_____ DOB: _____/_____/_____ Sex: M / F

Mailing Address: _____

City: _____ Zip: _____ County: _____

Emergency Contact: Please list the name and phone numbers of two friends/relatives who could contact you or take a message if necessary:

Name: _____

Phone Number: _(_____)_____-_____ □ Home □ Work □ Cell

Name: _____

Phone Number: _(_____)_____-_____ □ Home □ Work □ Cell

Who told you about the Child Development Center: □ Court Ordered □ Physician □ Social Services
□ Mental Health Provider □ Friend/Neighbor □ Community Services Board □ School
□ Other: _____

Number of siblings living in this Home: _____ Number of siblings living elsewhere: _____

Please list siblings living in this home:
Name: _____ DOB: _____/_____/_____ Sex: M / F

Name: _____ DOB: _____/_____/_____ Sex: M / F

Name: _____ DOB: _____/_____/_____ Sex: M / F

Name: _____ DOB: _____/_____/_____ Sex: M / F

Please give Complete Names, Addresses and Phone Numbers for the following facilities:

1. Where does your child receive medical care? _____

   Address: _____ Phone: (____) _____-_____

2. Has your child had any serious physical/medical problems? □ Yes □ No

   If **YES**, please list: _____

3. Has your child ever been hospitalized or had a significant head injury? □ Yes □ No

   If **YES**, list date, place and reason: _____

4. Please check the areas of concern and reason for seeking this evaluation:

___ Abuse/Neglect ___ Academics ___ Aggressiveness ___ Anxiety ___ Attention/Concentration

___ Bedwetting/Soiling Self ___ Coordination/Neurological ___ Depression

___ Developmental Delays ___ Discipline ___ Eating ___ Head Injury (Past) ___ Hyperactivity

___ Lying ___ Physical/Health ___ Sexual ___ Sleep ___ Socialization ___ Speech/Language

___ Stealing ___ Unusual Behavior/Thoughts **(Describe Below)** ___ Other **(Describe Below)**

5. Please describe your primary areas of concern / reason for seeking an evaluation in detail (Use back if necessary). *Evaluations due to Court Order also need to have an area of focus identified.*

_____

_____

_____

6. When did you first become concerned about your child? _____

_____

7. Has your child ever been seen by a Health Department? □ Yes □ No

If **YES**, list City/County: _____

8. Birth Hospital: _____

Address: _____ Phone: (____)_____-_____

Mother's name at the time of birth: _____

9. What medication(s) does your child take now or in the past (list all prescriptions and over-the-counter medications)?

Past_____

Current_____

10. Is your child known to a Department of Social Services? □ Yes □ No

If **YES**, please provide City/County: _____

11. Does your child attend school? □ Yes □ No If **YES**, which grade? _____ Grades Repeated: _____

School Name: _____ Teacher: _____

Address: _____ Phone: (____)_____-_____

12. Does your child receive Special Education or remedial services? □ Yes □ No

If **YES**, Describe: _____

13. Has this child **or any relative(s)** been previously evaluated at this Center? □ Yes □ No

If **YES**, please give name and date of evaluation:

_____ _____
(Name) (Approximate date of Evaluation)

14. Has your child had any previous studies done for this or any other difficulty? (Such as Psychological, Educational, Speech/Language, or Neurological Evaluations, etc.) If yes, list the names and dates:

_____

_____

15. What counseling or other mental health services has this child received? _____

_____

16. Has this child's biological mother, father, or sibling(s) experienced similar difficulties? □ Yes □ No

If **YES**, Describe: _____

If any additional space is required to answer these questions, please use the back of this sheet.

If this evaluation is being sought due to Court Order, a copy of the complete Court's Order must be included with this registration packet.

RECORD KEEPING

I understand that medical records will be retained for ten years after the date of the last visit or for five years following patient's death. In the case of a minor, the record will be retained ten years after the last visit or for five years after age 18, whichever comes later. I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. I request the third party payer to pay any authorized benefits to VDH on my behalf.

Please call our office at (540) 891-3151 should you have any questions regarding the completion of this Registration Packet.

I certify that the information I have provided is true and complete according to my best knowledge and belief.

_____ _____ _____
Signature Parent/Guardian Date Relationship to patient

BILLING INFORMATION

SECTION A – FEES FOR SERVICES: Virginia State Health Department does charge for services rendered at this Center. You will be responsible for paying for those services for which you receive, at the time services are rendered. Fees are based on a Sliding Scale. Sliding Scale is determined by the total household income and the total number of residents within that household. Our fees are set/determined by July 1st each year.

Should payment not be made at the time of service, we will establish an installment payment plan for the amount due. If installment payments are not made when they are due, a late fee of 10% of the total amount due will be added to your account. Delinquent accounts may also be sent to a collection agency and/or the Department of Taxation (which means that the amount owed on delinquent accounts will be taken out of your State tax refund or any lottery winnings) and an additional 25% collection fee will be added to your account. Some accounts may be forwarded to the Attorney General's office for collection, and there will be a 30% legal fee added to these collections. If your account is delinquent, future chargeable services may be denied. Payments can be made at any Health Department in the State via check, cash, money order, Visa or MasterCard.

To qualify for reduced charges the following information is required:

Household Members:

Total Adults: _____ + Total Children: _____ = Total Household Members: _____

Household Income:

Provider/Type	**Monthly**	**Yearly**
Mother: _____	$_____	$_____
Father: _____	$_____	$_____
Other: _____	$_____	$_____
Other: _____	$_____	$_____
Child Support: Yes _____ No _____	$_____	$_____

ANNUAL TOTAL HOUSEHOLD INCOME $_____

Proof of income must be attached/enclosed with this registration packet. Following are two acceptable forms of income proof.

1. A copy of your latest State Income Tax Return
2. Three months of past check stubs for each working member of the household. A check stub with Year-To-Date earnings (covering at least three months) will also be sufficient.

SECTION B – MEDICAID RECIPIENTS: PLEASE CHECK THE TYPE OF MEDICIAD YOUR CHILD/PATIENT HAS. YOU MUST ENCLOSE/ATTACH A COPY OF MEDICAID CARD.

_____ Virginia State Medicaid (No HMO)
_____ * Optima Medicaid HMO (**Referral Required From Primary Care Physician**)
_____ * Virginia Premier Medicaid HMO

*=These are the only Medicaid HMO's that recognize our service.

Name as it appears on Medicaid card: _____

Effective Date: _____/_____/_____

Medicaid Number: _____ Co-Pay Amount: $_____

IS THIS CHILD COVERED ON ANY ADDITIONAL INSURANCE POLICY? □ Yes □ No
IF **YES**, YOU MUST PROVIDE A COPY OF THAT INSURANCE CARD.

The Virginia Department of Health does not file private health insurance claims.

SECTION C – ORGANIZATIONS: Should a private organization (ie: Social Services Department, Public School, Community Services Board) agree to pay for this evaluation, a letter of commitment on their Letterhead Stationary must be attached/enclosed with this registration packet.

I HAVE READ AND UNDERSTAND THE BILLING INFORMATION AND THAT I AM ULTIMATELY FINANCIALLY RESPONSIBLE. I UNDERSAND THAT MY SIGNATURE IS REQUIRED FOR SECTIONS A, B, AND C PRIOR TO AN APPOINTMENT BEING SCHEDULED.

SIGNATURE: _____ DATE: _____/_____/_____

Parent/Legal Guardian

Attached/Enclosed with this registration you will find an **Authorization for Disclosure and Receipt of Protected Health Information** forms. These are used to obtain important records specific to your child. It is important that each of these forms be completed thoroughly including:

- **Beginning Date** (date you are giving this office permission to obtain your child's records)
- Organization(s) and/or Person (s) with Complete Addresses and Telephone Numbers
- Signature, relationship to child, and Date of signing

Virginia Department of Health - Office of Privacy and Security

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Authorization for Disclosure and Receipt of Protected Health Information

RE: _____ (Client/Child's Name)
Date of Birth: _____
Social Security/ID Number: _____

As the person signing this authorization, I understand that I am giving permission to Rappahannock Area Child Development Center beginning _____, and ending _____, to disclose AND RECEIVE ALL personal health and mental health information to the person(s) or organization(s) I have indicated for the purpose of a Comprehensive Developmental Evaluation.

- I understand the provision of treatment to me cannot be conditioned on my signing of this authorization.
- Any health information re-disclosed by you will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included with my medical record.
- I have a right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize the ***Rappahannock Area Child Development Center (RACDC)*** to disclose **AND RECEIVE** my health, developmental, psychological, educational, and other personal information to the following organization(s) or person(s):

Organization(s) or Person(s) With Addresses	**Information to be Disclosed**
Parents/Legal Guardians -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records
Primary Care Doctor -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records

This information is to be disclosed immediately.

If signing on behalf of the patient (i.e., signing on behalf of a minor child):

_____ _____
Please Print Client/Child's Name Parent/Legal Guardian Signature

_____ _____
Date Relationship to Client/Child

*****This form must be filed in the medical record***
*****A copy of this authorization is available to the patient upon request.***

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Authorization for Disclosure and Receipt of Protected Health Information

RE: _____ (Client/Child's Name)
Date of Birth: _____
Social Security/ID Number: _____

As the person signing this authorization, I understand that I am giving permission to Rappahannock Area Child Development Center beginning _____, and ending _____, to disclose AND RECEIVE ALL personal health and mental health information to the person(s) or organization(s) I have indicated for the purpose of a Comprehensive Developmental Evaluation.

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- Any health information re-disclosed by you will no longer be protected by this authorization.
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- I authorize the ***Rappahannock Area Child Development Center (RACDC)*** to disclose **AND RECEIVE** my health, developmental, psychological, educational, and other personal information to the following organization(s) or person(s):

Organization(s) or Person(s) With Addresses	**Information to be Disclosed**
Parents/Legal Guardians -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records
Hospitals (including birth) -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records

This information is to be disclosed immediately.

If signing on behalf of the patient (i.e., signing on behalf of a minor child):

_____ _____
Please Print Client/Child's Name Parent/Legal Guardian Signature

_____ _____
Date Relationship to Client/Child

*****This form must be filed in the medical record***
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Authorization for Disclosure and Receipt of Protected Health Information

RE: _____ (Client/Child's Name)
Date of Birth: _____
Social Security/ID Number: _____

As the person signing this authorization, I understand that I am giving permission to Rappahannock Area Child Development Center beginning _____, and ending _____, to disclose AND RECEIVE ALL personal health and mental health information to the person(s) or organization(s) I have indicated for the purpose of a Comprehensive Developmental Evaluation.

- I understand the provision of treatment to me cannot be conditioned on my signing of this authorization.
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- I authorize the ***Rappahannock Area Child Development Center (RACDC)*** to disclose **AND RECEIVE** my health, developmental, psychological, educational, and other personal information to the following organization(s) or person(s):

Organization(s) or Person(s) With Addresses	**Information to be Disclosed**
Parents/Legal Guardians -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records
School -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records

This information is to be disclosed immediately.

If signing on behalf of the patient (i.e., signing on behalf of a minor child):

_____ _____
Please Print Client/Child's Name Parent/Legal Guardian Signature

_____ _____
Date Relationship to Client/Child

*****This form must be filed in the medical record***
*****A copy of this authorization is available to the patient upon request.***

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RE: _____ (Client/Child's Name)
Date of Birth: _____
Social Security/ID Number: _____

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- Any health information re-disclosed by you will no longer be protected by this authorization.
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- I authorize the ***Rappahannock Area Child Development Center (RACDC)*** to disclose **AND RECEIVE** my health, developmental, psychological, educational, and other personal information to the following organization(s) or person(s):

Organization(s) or Person(s) With Addresses	**Information to be Disclosed**
Parents/Legal Guardians -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records
Mental Health Provider/Counselor/Therapist -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records

This information is to be disclosed immediately.

If signing on behalf of the patient (i.e., signing on behalf of a minor child):

_____ _____
Please Print Client/Child's Name Parent/Legal Guardian Signature

_____ _____
Date Relationship to Client/Child

*****This form must be filed in the medical record***
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Rev: May 2007

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Authorization for Disclosure and Receipt of Protected Health Information

RE: _____ (Client/Child's Name)
Date of Birth: _____
Social Security/ID Number: _____

As the person signing this authorization, I understand that I am giving permission to Rappahannock Area Child Development Center beginning _____, and ending _____, to disclose AND RECEIVE ALL personal health and mental health information to the person(s) or organization(s) I have indicated for the purpose of a Comprehensive Developmental Evaluation.

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Organization(s) or Person(s) With Addresses	**Information to be Disclosed**
Parents/Legal Guardians -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records
Social Services -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records

This information is to be disclosed immediately.

If signing on behalf of the patient (i.e., signing on behalf of a minor child):

_____ _____
Please Print Client/Child's Name Parent/Legal Guardian Signature

_____ _____
Date Relationship to Client/Child

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RE: _____ (Client/Child's Name)
Date of Birth: _____
Social Security/ID Number: _____

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Organization(s) or Person(s) With Addresses	**Information to be Disclosed**
Parents/Legal Guardians -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records
Court -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records

This information is to be disclosed immediately.

If signing on behalf of the patient (i.e., signing on behalf of a minor child):

_____ _____
Please Print Client/Child's Name Parent/Legal Guardian Signature

_____ _____
Date Relationship to Client/Child

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Organization(s) or Person(s) With Addresses	**Information to be Disclosed**
Parents/Legal Guardians -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records
Community Service/Agency -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records

This information is to be disclosed immediately.

If signing on behalf of the patient (i.e., signing on behalf of a minor child):

_____ _____
Please Print Client/Child's Name Parent/Legal Guardian Signature

_____ _____
Date Relationship to Client/Child

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Organization(s) or Person(s) With Addresses	**Information to be Disclosed**
Parents/Legal Guardians -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records
Other Facility/Organization -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records

This information is to be disclosed immediately.

If signing on behalf of the patient (i.e., signing on behalf of a minor child):

_____ _____
Please Print Client/Child's Name Parent/Legal Guardian Signature

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Date of Birth: _____
Social Security/ID Number: _____

As the person signing this authorization, I understand that I am giving permission to Rappahannock Area Child Development Center beginning _____, and ending _____, to disclose AND RECEIVE ALL personal health and mental health information to the person(s) or organization(s) I have indicated for the purpose of a Comprehensive Developmental Evaluation.

- I understand the provision of treatment to me cannot be conditioned on my signing of this authorization.
- Any health information re-disclosed by you will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included with my medical record.
- I have a right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize the ***Rappahannock Area Child Development Center (RACDC)*** to disclose **AND RECEIVE** my health, developmental, psychological, educational, and other personal information to the following organization(s) or person(s):

Organization(s) or Person(s) With Addresses	**Information to be Disclosed**
Parents/Legal Guardians -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records
Facility/ Organization -	All Medical, Psychiatric, Psychological, Sociological, Educational, & Developmental Records

This information is to be disclosed immediately.

If signing on behalf of the patient (i.e., signing on behalf of a minor child):

_____ _____
Please Print Client/Child's Name Parent/Legal Guardian Signature

_____ _____
Date Relationship to Client/Child

*****This form must be filed in the medical record***
*****A copy of this authorization is available to the patient upon request.***